Auburn University Youth Program/Camp Medical Information and Release Form

PROGRAM/CAMP INFORMATION	<u>DN</u>				
Program/Camp Name:				(here	after "Program")
Date(s):	Time(s):				
Location:					
As a student, parent or guardian I of any pre-existing medical condition recreational time may not be recommended. Auburn University requests that we can provide and/or seek apprefinal determination about whether issue that is not requested below, but consult with a physician prior to particle responsibility to consult with your of answer yes to any of the following quantum services.	as. If Participant has a prended. <i>This informat</i> ests the information be opriate treatment for Pato participate is the rat which you think is cipating in this Program wn physician prior to	pre-existing me fion will be kep low so that, in articipant. You responsibility of important, plea m. If you are un participating ir	dical condition of in strict concase of emerare accountable f you and you see include the certain about this Program	on, participation in any sonfidence and will only gency, we will have accorden for providing an accorden physician. If Particat information. It is reany preexisting medican. Please answer all of	strenuous activities or be shared with your curate information so urate medical history. ipant has any medical commended that you I conditions, it is your the questions. If you
I understand that Auburn University	does not offer any for	m of insurance	for participa	ent while participating i	n Program.
PART 1. GENERAL INFORMATI	ON				
Participant Name				(here	after "Participant")
Parent/Legal Guardian Name (if appli	cable)				
Street Address	City _			_State	Zip
Home Phone		Work Phone			
Date of Birth//	<u> </u>	Gender	М	F	
Please list two emergency contacts:					
Emergency Contact #1 Name	Home Phone #	Work Ph	one #	Cell Phone #	Relation
Emergency Contact #2 Name	Home Phone #	Work Pl	one #	Cell Phone #	Relation
PART 2. MEDICAL INFORMATI	ON				
It is recommended that Participant copreexisting medical conditions, <i>it is</i> Please answer all of the questions. If additional paper if needed.	your responsibility to	consult with y	our own phy	sician prior to participa	ating in this Program.
Physician's Name			Phone	Number	
Date of most recent tetanus toxoid	immunization				
Do you have health/accident insur		YES NO			

If yes, please indicate policy number, name and address of insurance company.

Company Name / Address	Policy #		
PLEASE ENCLOSE A COPY OF THE FRONT AND BA	ACK OF YOUR INSURANCE CARD WITH THIS FOR	M	
For the following, circle appropriate response and explain Does participant have any limiting medical conditions that yo If yes, identify and explain:		YES	NO
Is participant currently taking medication that may interfere w If yes, please indicate the medication and the condition being		YES	NO
Does participant have a history of allergies or reactions to me If yes, please explain:	dications, insect stings, or plants?	YES	NO
Does participant have a history of, or currently suffer from, m If yes, please explain:	nedical condition(s) with which we need to be aware?	YES	NO
PART 3: AUTHORIZATION FOR MEDICAL CARE			
Unless prior arrangements have been made, medical ne cases where medical attention is necessary, parents with medical treatment can be provided, we are required to have will not perform services unless this form is presented a	will be contacted for approval when possible. How have a medical release signed by the parent/guardian.	ever, b	efore
Participant has my permission to receive medical a participating in this Program. I will assume the financial occur during this Program.			
As a participant, parent, or guardian I understand and a result in harm to Participant and/or others during this I provided all materials and important information to Aut physical condition and that it is accurate and complete. physical or medical condition prior Participant's schedu	Program. By signing my name I represent and warrant ourn University pertaining to my Participant's medical I agree to notify Auburn University of any changes in	t that I l, menta	have al and
By revealing or disclosing the above medical informemployees to determine Participant's ability to participate participate in activities, he/she do so voluntarily and of solely the responsibility of myself and Participant.	ate safely in activities. I understand that, if Participar	nt choos	ses to
Participant Name	Parent/Guardian Name		
Participant Signature	Parent/Guardian Signature		

Date _____

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 19

Date _____